CMS

ILLINOIS
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

WAIVING ANNUITANT GROUP INSURANCE COVERAGE
NOTIFICATION AND ELECTION FORM

In accordance with Public Act 93-553, this Notification and Election Form is provided to State of Illinois Retirement Systems Annuitants to inform them of the consequences of electing to participate in the State Employees Group Insurance Program as a *Dependent*, and the conditions and procedures for re-enrolling at a later time as an eligible *Member*. By completing this waiver and signing below, a person eligible to participate in the Group Insurance Program as an Annuitant, can elect to waive health, dental and vision Group Insurance coverage, and instead participate as a dependent of their spouse.

Dependent Name: _____	**Spouse Name: _____**
Dependent SSN: _____	**Spouse SSN: _____**
Daytime Phone #: _____	**Daytime Phone #: _____**

I fully understand and certify to the following:

1. In electing to participate in the health plan as a dependent of my eligible Spouse, I acknowledge that I am waiving health, dental and vision coverage as an Annuitant.

2. I will be enrolled as an Annuitant with Basic Life insurance coverage. If I currently have optional life coverage, I have the option of continuing that coverage. Statement of Health approval will be required to obtain additional optional life insurance coverage.

3. I cannot be enrolled in Spouse Life coverage as a dependent of my eligible spouse.

4. Re-enrollment in the health, dental and vision Program as an eligible Member can be done only during the annual Benefit Choice period (May 1-31 of each year) or within 60 days of a qualifying Change in Status. If I wish to re-enroll, I must contact my Group Insurance Representative to complete and sign the Initial Enrollment form (CMS-310), and submit the required back-up documentation.

Dependent Signature: _____ Date: _____

GIR/P USE ONLY

Effective date Dependent is/was added to Spouse's H/D/V plan: _____

Effective Date of Dependent Annuity: _____

Comments:_____

_____

_____ _____
Group Insurance Representative Signature/Date Phone #

_____ _____
Agency Name Organizational Processing Code